109. AUDIT FUNCTION:

After the hospital has submitted the annual cost report, the Program will perform a limited desk review. The purpose of a desk review is to verify prior year cost to be used in setting the prospective rate. The Medicare intermediary will be informed of any findings as a result of this desk review. Under a common audit agreement, the Medicare intermediary performs any audit required for both Title XVIII and Title XIX purposes. However, the Program may choose to audit even though Medicare does not.

110. PAYMENT OF DUAL LICENSED AND SWING BEDS

A. State Defined Dual Licensed Acute Care Beds

Pursuant to legislation enacted by the 1986 General Assembly, a licensed acute care hospital may obtain a dual license for twenty-five (25) licensed acute care beds or 10% of the hospital's total licensed acute care bed capacity, whichever is greater, but not to exceed 40% of the hospital's total licensed acute care bed capacity, to provide intermediate or skilled nursing care in such beds.

Effective July 1, 1987, the Kentucky Medical Assistance Program will reimburse acute care hospitals for intermediate care and/or skilled nursing services provided to patients placed in dual licensed beds. The reimbursement rate for routine services is the upper limit (maximum payment) for intermediate care facilities or hospital based skilled nursing facilities, depending on the level of care requirements of the patient in the dual licensed bed.

B. Federally Defined Swing Beds

Federally defined swing beds are reimbursed by the Kentucky Medical Assistance Program at the weighted average payment rate

for routine services for the prior calendar year for all intermediate care facilities (excluding intermediate care facilities for the mentally retarded and developmentally disabled) or skilled nursing facilities in the state, depending on the level of care requirements of the patient in the swing bed.

C. Ancillary Services for Dual Licensed and Swing Beds

Payments for reimbursable ancillary services provided to intermediate care or skilled nursing patients in dual licensed or swing beds are based on a percent of charges with a settlement to actual cost at the end of the facility's fiscal year. Ancillary services covered shall be the same ancillary services as are covered in the regular skilled and intermediate care setting.

At the end of each facility's fiscal year a KMAP-2 and a KMAP-3 must be filed with the cost report so that the Program can make final settlement on the ancillary services provided to patients in dual licensed beds. A separate KMAP-2 and KMAP-3 should be completed for each level of care, i.e., dual licensed ICF or SNF. For swing beds, the usual Medicare cost report forms should be completed.

111. REIMBURSEMENT REVIEW APPEAL PROCESS:

Participating hospitals are provided a mechanism for a review of Program decisions when any of the following circumstances occur:

(1) The addition of new and necessary services requiring Certificate of Need approval.

(2) Major changes in case mix.

(3) Major changes in types/intensity of services.

(4) Costs of improvements incurred because of. certification or licensing requirements established after payment rates were established if those cost. were not considered in the rate calculation.

(5) Extraordinary circumstances which may include but are not limited to fires, floods, etc.

(6) Program decisions of a substantive nature relating to the application of this payment system.

The request for a review should follow the review and appeals mechanism set forth in 907 KAR 1:671, Conditions of Medicaid Provider Participation; Enrollment. Documentation of Services, Disclosure, Claims Processing. Withholding Overpayments,Appeals Process, and Sanctions.

within 45 days after one of the above circumstances occurs or the notification of the facility of its prospective rate. The dollar amount and the issue in question should be clearly identified and must be supported by generally accepted accounting principles. The burden of proof shall be on the hospital to demonstrate that costs for which additional reimbursement is being requested are necessary, proper, and consistent with efficient and economical delivery of covered inpatient care services.

Upon receipt of the request for review, the Division will determine the need for a Program/Vendor conference and will contact the facility to arrange a conference if needed. The conference, if needed, must be held within 60 days of the Program's receipt of the hospital's request for review unless delayed due to extenuating circumstances. Regardless of the Program decision, the provider will be afforded the opportunity for a conference if he/she so wishes for a full explanation of the factors involved and the Program decision. Following review of the matter, the Director will notify the facility of the action to be taken by the Division within 20 days of receipt of the request for review or the date of the Program/Vendor conference, except that additional time may be taken as necessary to secure further information or clarification pertinent to the resolution of the issue.

(b) If the facility does not agree with the decision(s) of the Director, Division of Reimbursement Operations, the facility may then appeal the question to a Reimbursement Review Panel established by the Commissioner of the Department for Medicaid Services which will include one member of the Division of Reimbursement Operations, a representative of the Kentucky Hospital Association and a member of the Department for Medicaid Services (but not within the Division of Reimbursement Operations) as designated by the Commissioner, with such designated member to serve as chairperson.

The request for review by the Reimbursement Review Panel must be postmarked within 20 days following the notification of the initial decision by the Director, Division of Reimbursement Operations. A date for the Reimbursement Review Panel to convene will be established within 20 days after receipt of a written request for such appeal. The question will be heard by the Panel and a binding decision issued within 30 days of the hearing of the issue, except that additional time may be taken as necessary to secure further information or clarification pertinent to the resolution of the issue. In carrying out the intent and purposes of the Program, the Panel may take into consideration extenuating circumstances which must be considered in order to provide for equitable treatment and reimbursement of the provider.

State Kentucky

INSTRUCTIONS FOR SUPPLEMENTAL MEDICAID SCHEDULE
KMAP-1

NOTE: FOR HCFA-2552-89 (12-89)

Line 1 - Enter amount paid as legal fees associated with lawsuits brought against the Cabinet for Human Resources. (See Title XIX Inpatient Hospital Reimbursement Manual "General Policies and Guidelines," Section 106, Page 106.01, item b.)

Line 2 - Enter all expenses associated with political contributions.

Line 3 - Enter all expenses associated with travel outside the Commonwealth.

Line 4 - Enter HICAP Assessment amount.

Line 5 - Sum of lines 1, 2, 3, and 4.

Column 3 Enter amounts from HCFA-2552-89, Worksheet B, Part I, Column 27 on the appropriate lines, as indicated. Note that Lines 11A and 11B are taken from Worksheet D-2 as indicated and the total of these two should equal the amount of Worksheet B, Part I, Line 70.

Line 14 - Enter sum of lines 6 through 13.

Line 15 - Enter amount from line 5.

Line 16 - Divide the non-allowable cost on line 15 by the total cost on line 14 and enter answer.

Column 4 Lines 6 through 13 - Multiply the ratio from line 16 by each amount entered on lines 6 through 13 and enter answers on the appropriate line of column 4.

Line 14 - Enter sum of line 6 through 13. Sum in Column 4, line 14 should equal the non-allowable cost on Line 5.

Line 17 - Enter only the sum of Lines 6A, 7, and 11A. Line 6B should only be included if the cost is applicable to a psychiatric or rehabilitation unit.

Line 18 - Divide the Medicaid Inpatient Allowable Cost (HCFA-2552-89, 12/89, Worksheet E-3, Part III, Total of Lines 1 through 6 plus 7B) by the Total Inpatient Allowable Cost (HCFA-2552-89), Worksheet B, Part I, Column 27, Total expenses less amounts on Line 60 through to total expenses with the exception of Line 70 which should be included in Total Inpatient Allowable Cost).

Line 19 - Multiply the amount entered on Line 17 by the ratio on Line 18 to determine the Medicaid portion of the non-allowable cost.

Line 20 - Deduct the amount entered on Line 19 from the Medicaid Inpatient Allowable Cost (HCFA-2552-89, Worksheet E-3, Part III, Line 8).

Line 21 - Enter only the sum of the amount of non-allowable cost from Lines 8 and 11B.

Line 22 - Divide Medicaid Outpatient Allowable Cost (HCFA-2552-89, Worksheet E-3, Part III, Column 2, Line 8) by the Total Outpatient Allowable Cost (HCFA-2552-89) Worksheet B, Part I, Column 27, Lines 60 through 62.

Line 23 - Multiply the ratio from Line 22 by the amount from Line 21.

Line 24 - Deduct the amount on Line 23 from the amount entered on Worksheet E-3, Part III, Column 2, Line 8.

State Kentucky

SUPPLEMENTAL MEDICAID SCHEDULE KMAP-1

Computation of Legal Fees, Political Contributions, HICAP Assessment, and Out-of-State Travel not Allowable to KMAP

Legal Fees _____
Political Contributions _____
Out-of-State Travel _____
HICAP Assessment _____
Total Non-Allowable Cost _____

HOSPITAL _____
VENDOR NO _____
PERIOD FROM _____
PERIOD TO _____

Column 1 COST CENTERS	Column 2 From Medicare Cost report Worksheet B Part 1	Column 3 Accumulated Costs	Column 4 Allocated Non-Allowable Costs
Inpatient routine Service A. Hospital	Total of Lns. 25-30 & 33		
B. Sub Providers (other than Inpatient Hospital)	Lns. 31, 32, 34-36		
Ancillary Service Cost Center	Total of Lines 37-59		
Outpatient Service Cost Centers	Tot Lns. 60-62		
Home Program Dialysis	Ln. 63		
Ambulance Services	Ln. 64		
1A. Intern-Res. Srvc. Not Appr. (I/P) D-2, Ln. 19, Col. 2*	Ln. 70		
1B. Intern-Res. Srvc. Not Appr. (O/P) D-2, Line 23, Col. 2*			
2. Other Cost Centers	Ln. 71-94		
3. Non-Reimbursable Cost Centers	Tot. Lns. 96-100		
4. Total Expenses (Sum of Lns. 6-13)			
5. Total Non-Allowable Costs (Line 5)			
6. Unit Cost Multiplier (Ln. 15 / Ln. 14)			
7. Non-Allowable Cost Applicable to Inpt. Costs			
8. Medicaid Inpatient Allowable Cost (Supplemental Worksheet E-3, Part III. Total of Lns. 1 thru 6 plus 7b, excluding all outpt.) divided by the total Inpt. allowable hospital cost (Worksheet B, Part I) See Instructions Attached			
9. Medicaid Non-Allowable Cost Line 17 X Line 18			
10. Medicaid Allowable Cost. Deduct the amount entered on Line 19 from the Title XIX Inpatient Cost on E-3 Part III, Col 1, Line 8			
OUTPATIENT			
11. Non-Allowable cost applicable to outpatient cost from line 8 and 11B.			
12. Determination of Medicaid Non-allowable Cost. (See Instructions Attached)			
13. Medicaid Non-Allowable Outpatient Cost. (Line 21 X Line 22)			
14. Medicaid Allowable Outpatient Cost. Deduct the amount entered on Line 23 from the Title XIX Outpatient Cost on E-3 Part III Col 2 Line 8			

Costs are broken between Inpatient and Outpatient Departments on W/sheet D-2

KMAP-2

SUPPLEMENTAL MEDICAID SCHEDULE

COMPUTATION OF DUAL LICENSED ANCILLARY COST

HOSPITAL _____ ICF DUAL LICENSED PROVIDER NUMBER _____

VENDOR NUMBER _____ SNF DUAL LICENSED PROVIDER NUMBER _____

ANCILLARY COST CENTERS	TOTAL ANC. COST COL. 1	TOTAL DIRECT COST COL. 2	DIRECT COST % COL.3 (2/1)	TOTAL INDIR. COST COL. 4	INDIR. COST % COL. 5 (4/1)	RATIO OF COST TO CHG COL.6	DIRECT COST TO CHG RATIO COL. 7 (6X3)	MEDICAID DUAL INPATIENT CHARGES (BILLED) COL. 8	INPATIENT DIRECT COST COL. 9 (7X8)	INDIRECT COST TO CHG. RATIO COL. 10 (6 X 5)	MEDICAID DUAL CHARGE (BILLABLE & NON-BILLABLE UNDER SNF) COL. 11	INPATIENT INDIRECT COST COL. 12 (10 X 11)
41 RADIOLOGY-DIAGNOSTIC												
42 RADIOLOGY-THERAPEUTIC												
43 RADIOISOTOPE												
44 LABORATORY												
45 PBP CLINIC LAB SVC-PRG. ONLY												
46 WHOLE BL. & PK. RED BL. CELLS												
48 IV THERAPY												
49 RESPIRATORY THERAPY												
50 PHYSICAL THERAPY												
51 OCCUPATIONAL THERAPY												
52 SPEECH PATHOLOGY												
53 ELECTROCARDIOLOGY												
54 ELECTROENCEPHALOGRAPHY												
55 MED. SUPPLIES CHG. TO PT.												
56 * DRUGS CHARGED TO PATIENTS												
101 TOTAL												

104 AMOUNT RECEIVED FROM THE MEDICAID PROGRAM (FROM PROGRAM PAID CLAIMS LISTING) _____

105. AMOUNT DUE PROGRAM/PROVIDER (LINE 101, COL. 9 LESS LINE 104) _____

INSTRUCTIONS

1. TOTAL ANCILLARY COSTS FROM HCFA-2552-89, WORKSHEET C, COLUMN 3
2. ALL COST ALLOWABLE UNDER MEDICAID IC/SNF RULES AS DIRECT COST
3. COLUMN 2 DIVIDED BY COLUMN 1
4. ALL OTHER ANCILLARY COST (COLUMN 1 LESS COLUMN 2)
5. COLUMN 4 DIVIDED BY COLUMN 1
6. RATIO OF COST TO CHARGES FROM HCFA-2552-89, WORKSHEET C, COL. 6
7. COLUMN 6 MULTIPLIED BY COLUMN 3
8. DUAL LICENSED CHARGES BILLED TO THE MEDICAID PROGRAM
9. COLUMN 7 MULTIPLIED BY COLUMN 8
10. COLUMN 6 MULTIPLIED BY COLUMN 5
11. ALL DUAL LICENSE CHARGES INCLUDING THOSE CHARGES BILLABLE AND NON-BILLABLE TO THE MEDICAID IC/SNF PROGRAM. SHOULD NOT INCLUDE THOSE CHARGES CONSIDERED TO BE NON-ALLOWABLE COST FOR SERVICES IN A LONG TERM CARE SETTING
12. COLUMN 10 MULTIPLIED BY COLUMN 11. TRANSFER THIS AMOUNT TO KMAP-3, LINE 13

* COST AND CHARGES PRIOR TO OCTOBER 1, 1990 ONLY

State Kentucky

Approval Date 1/31/96 Effective Date 7-1-92
TN No. 92-16
Supersedes
TN No. 91-06

KMAP-3

SUPPLEMENTAL MEDICAID SCHEDULE

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR DUAL LICENSED BEDS

HOSPITAL _____

VENDOR # _____

PERIOD FROM _____ PERIOD TO _____

*1.	Dual-licensed NF-type Medicaid inpatient days	
2.	Dual-licensed SNF-type Medicaid inpatient days	
3.	Dual-licensed ICF-type Medicaid inpatient days	
*4.	Medicaid rate for dual-licensed NF bed services	
5.	Medicaid rate for dual-licensed SNF bed services	
6.	Medicaid rate for dual-licensed ICF bed services	
*7.	Medicaid payments for dual-licensed NF-type services (Line 1 x Line 4)	
8.	Medicaid payments for dual-licensed SNF-type services (Line 2 x Line 5)	
9.	Medicaid payments for dual-licensed ICF-type services (Line 3 x Line 6)	
10.	Total Medicaid payments for dual-licensed services (Line 7 + Line 8 + Line 9)	
11.	Total Medicaid dual licensed inpatient routine service cost	
12.	Medicaid dual licensed inpatient routine service cost net of dual-licensed payments (Line 11 - Line 10)	
13.	Indirect cost for ancillary services rendered to dual-licensed patients	
14.	Total unreimbursed Medicaid dual license inpatient service cost (Line 12 + Line 13)	

INSTRUCTIONS

Line #

1. From the Medicaid program's Paid Claims Listings
2. From the Medicaid Program's Paid Claims Listings
3. From the Medicaid Program's Paid Claims Listings
13. Transfer from KMAP-2 Line 101, Column 12
14. Line 12 plus line 13. Transfer this amount to HCFA 2552-89, worksheet E-3, Part III, line 7A

* Effective for services provided after October 1, 1990

TN No. 91-6
Supersedes Approved MAY 08 1991 Effective Date 1-1-91